U.S. Department of Labor

Office of Administrative Law Judges
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In the Matter of

GEORGE W. SHORES
Claimant

v.

MIDLAND COAL CORPORATION
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Date Issued: November 15, 2000

Case No.: 1999-BLA-1316

APPEARANCES: Mr. Thomas E. Johnson, Attorney
For the Claimant

Mr. L. Robert Mueller, Attorney
For the Employer

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS

This matter involves a claim filed by Mr. George Shores for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

I conducted a formal hearing in Peoria, Illinois, on June 15, 2000, attended by Mr. Shores, Mr. Johnson, and Mr. Mueller. A representative for the Director elected not to attend. My decision in this case is based on the testimony presented at the hearing and all documents admitted into evidence (DX 1 to DX 20, CX 1 to CX 3, and EX 1 to EX 4).[1]

Coal Miner's Background

Mr. Shores was born on February 22, 1919 and married Mrs. Geraldine Hazel Smith Shores on August 5, 1939 (DX 1). Mr. Shores and his wife have been married for over sixty years and continue to live together (TR, page 36). Mr. Shores spent almost 30 years of his life as a coal miner in Illinois, primarily working on surface or strip mines as a welder (TR, pages 37 and 39).[2] As a welder, Mr. Shores frequently lifted and carried 70 to 80 pounds by himself and up to 300 pounds with the aid of other miners (TR, page 42 through 53). His last job at Midland Coal found him welding at the tipple, in the garage, at the dragline (*see* CX 3), and on a loading shovel (TR, page 39). In 1982, Mr. Shores retired from mining due to shortness of breath and has not worked since (TR, pages 54 and 61).

Mr. Shores' breathing problems have gotten progressively worse since 1996, and he currently experiences severe shortness of breath upon the slightest exertion, such as climbing stairs, walking any distance, and after showering and dressing (TR, pages 56 and 66). For the past two years, he has received oxygen therapy in addition to inhalers and pills to ease his breathing difficulties (TR, pages 56 and 57). Mr. Shores smoked a half pack of cigarettes a day for little over 30 years, from 1940 until New Year's Day, 1971, when he quit (TR, page 60). Unfortunately, in 1998, Mr. Shores suffered a heart attack (TR, page 62).

Procedural Background

Previous Claims

Mr. Shores has filed three previous claims for black lung disability benefits with the United States Department of Labor ("DOL"). His first claim, filed on May 28, 1981, was denied by DOL on July 25, 1981 because he failed to establish any element of entitlement (DX 16). Mr. Shores filed his second claim on October 5, 1994. DOL denied this claim on November 28, 1994 because Mr. Shores failed to

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[1]The following notations appear in this decision to identify specific evidence: DX - Director exhibit, ALJ - Administrative Law Judge exhibit, EX - Employer's exhibit, CX - Claimant's exhibit; and, TR - Transcript of hearing. In response to the partial late submission of CX 2 to the employer's counsel, I kept the record open post-hearing to give Mr. Mueller an opportunity to have a medical expert respond to the medical records in CX 2 (TR, pages 19 to 29). On July 21, 2000, I received Dr. Selby's July 16, 2000 review of the claimant's medical record and now admit that document as EX 4.

[2]Since Mr. Shores last mined coal in Illinois, the U.S. Court of Appeals for the Seventh Circuit has jurisdiction. *See Shupe v. Director, OWCP*, 12 B.L..R 1-200, 1-202 (1989)(en banc).

respond to a Show Cause Order concerning his failure to schedule a pulmonary examinations (DX 17). Mr. Shores submitted his third claim on July 29, 1996. On November 5, 1996, DOL also denied the claim for failure to establish any element of entitlement (DX 18).

Present Claim

On November 21, 1998, Mr. Shores presented his fourth, and present, claim to DOL for black lung disability benefits (DX 1). On May 13, 1999, DOL denied the claim for failure to show any element of entitlement (DX 11). Mr. Shores, through counsel, appealed this denial on July 12, 1999 (DX 13) and DOL forwarded his claim to the Office of Administrative Law Judges on September 3, 1999 (DX 19). Pursuant to a Notice of Hearing, dated April 5, 2000, I held the hearing on June 15, 2000 (ALJ 1).

ISSUES

1. Whether Mr. Shores, in filing a duplicate claim in November 1998, has established a material change in condition since the denial of his prior claim on November 5, 1996.

2. If a material change is established, whether Mr. Shores is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: (1) Mr. George Shores was a coal miner with post 1969 coal mine employment; (2) Mr. Shores has at least twenty-six years and six months of coal mine employment; (3) Mrs. Geraldine Shores is a dependant for the purposes of augmenting any benefits that may be payable under the Act; and, (4) Midland Coal Corporation ("Midland") is the responsible operator (TR, pages 12 and 69).

Issue # 1 - Material Change in Conditions

Any time within one year of a denial or award of benefits, any party to the proceeding may request a modification based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. §725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied on the basis of the prior denial unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. §725.309 as interpreted by the Benefits Review Board (BRB) and federal Courts of Appeals. Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corporation v. Ross*, 42 F.3d 993, 997-998 (6th Circuit 1994):

[T]o assess whether a material change is established, the ALJ must consider all of the new

> evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

I interpret the *Sharondale* approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

Mr. Shores did not effectively pursue his last, prior claim following its denial, effective November 5, 1996, within the one year time span established by 20 C.F.R. §725.310. Instead, he submitted the present, duplicate claim on November 21, 1998. Consequently, 20 C.F.R. §725.309 controls the adjudication of his current claim. In his last claim, Mr. Shores failed to establish any element of entitlement. As a result, to demonstrate a material change in condition has occurred since the denial of his prior claim, Mr. Shores must prove, based on evidence developed since November 1996, at least one element of the entitlement under the Act.

Elements of Entitlement

Under the Act, to receive benefits, a claimant must prove by a preponderance of the evidence several facts. First, the coal miner must establish the presence of pneumoconiosis. In the regulation, "pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment. The definition further includes "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[3] Under the Act, the legal definition of pneumoconiosis is much broader than "medical pneumoconiosis." *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Circuit 1996).

Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] If a miner who

[3] 20 C.F.R. §718.201.

[4] 20 C.F.R. §718.203 (a).

is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[5] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[6] Third, the coal miner must demonstrate total disability.[7] And fourth, the coal miner must prove the total disability is due to pneumoconiosis.[8]

The first step in the material change process requires the identification of the elements a claimant failed to prove in the prior claim. The basis for DOL's 1996 denial of Mr. Shores' third claim was a failure to prove any element of entitlement. Accordingly, I will evaluate the new evidence since November 1996 to see if Mr. Shores can establish proof of any element of entitlement. And, because the second and fourth elements of entitlement require a preliminary finding of the first and third elements, Mr. Shores, to show a material change in conditions, must demonstrate that he now has pneumoconiosis or is totally disabled from a respiratory perspective.

Presence of Pneumoconiosis

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§718.202 (a)(1)), autopsy or biopsy report (§718.202 (a)(2)), regulatory presumption (§718.202 (a)(3))[9], and physician opinion (§718.202 (a)(4)). Because the record does not contain any evidence of complicated pneumoconiosis and Mr. Shores applied for Federal black lung disability benefits in his present claim after January 1, 1982, the regulatory presumption of pneumoconiosis is not applicable. In addition, the official record obviously does not contain an autopsy report. And, there is no biopsy report. Mr. Shores must rely on chest x-ray evidence or medical opinion developed since November 1996 to establish the existence of pneumoconiosis.

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[5]20 C.F.R. §718.203 (b).

[6]20 C.F.R. §718.203 (c).

[7]20 C.F.R. §718.204 (b).

[8]20 C.F.R. §718.204 (a).

[9]If any of the following presumptions are applicable, then under 20 C.F.R. §718.202 (a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. §718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. §718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. §718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays

The following table summarizes the relevant chest x-ray interpretations in the official record.

Date of X-Ray	**Exhibit**	**Physician**	**Interpretation**
June 25, 1998	CX 2	Malik	COPD.[10] No acute cardiopulmonary pathology, no significant change since December 1995. Emphysematous thoracic cage with pulmonary hyperinflation and flattening of diaphragm. No infiltrates, congestion, failure or effusion.
July 29, 1998	CX 2	Malik	No acute cardiopulmonary pathology.
February 16, 1999	DX 8	Whitehouse BCR[11]	Borderline early changes of COPD, without congestion or infiltrating lung changes. Basal bronchial thickening is noted that might raise the possibility of bronchial or peribronchial inflammatory condition: to be clinically coordinated.
Same	DX 9	Cohen, B	Negative for pneumoconiosis. Bullae[12] and emphysema.
Same	DX 10	Sargent, BCR, B	Negative for pneumoconiosis. Possible emphysema.
March 27, 1999	CX 2	Malik	Mild emphysema. No infiltrates, congestion, or effusion. No acute cardiopulmonary pathology. No significant change when compared to previous study of July 29, 1998.

None of the physicians who reviewed Mr. Shores' chest x-rays developed since November 1996 found any evidence of pneumoconiosis. As a result, Mr. Shores is not able to establish the presence of pneumoconiosis through radiographic evidence.

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[10]Chronic Obstructive Pulmonary Disease.

[11]The following designations apply: B - B Reader, and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[12]Large vesicles, more than 5 mm in circumference, containing serous or seropurulent fluid. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 236(28th ed. 1994).

Medical Opinion

Prior to evaluating the medical opinion, a review of Mr. Shores' pulmonary and respiratory test results is helpful.

Pulmonary Function Test

Exhibit	**Date/ Doctor**	**Age/ height**	**FEV_1** pre[13] post[14]	**FVC** pre post	**MVV** pre post	**%FEV_1/ FVC** pre post	**Qualified**[15] pre post	**Comments**
DX 5	February 16, 1999 Cohen/Marder	80 69"	1.95	4.15	59[16]	47%	No[17]	Normal FCC, mildly reduced FEV, severely reduced FEV1/FVC ratio. Lung volumes are normal. Diffusion is reduced with low Dl/Va indicative of an altered gas exchanging surface.

[13]Test result before administration of a bronchodilator.

[14]Test result following administration of a bronchodilator.

[15]To qualify for total disability, for a miner's age and height, the FEV_1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. §718, **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV_1/FVC has to be equal or less than 55%.

[16]On the Department of Labor form, Dr. Cohen recorded Mr. Shores' MVV as 73. However, the computerized results of the pulmonary function tests indicate that Mr. Shores' MVV was 59. Accordingly, I find that 59 was Mr. Shores' MVV in this testing series.

[17] The qualifying FEV_1 number is 1.79 for age 71 (the greatest age referenced in the regulations) and 68.9". The associated qualifying FVC and MVV values are 2.31 and 72.

Arterial Blood Gas Studies

Exhibit	**Date/ Doctor**	**$_pCO_2$** (rest) **$_pCO_2$** (exercise)	**$_pO_2$** (rest) **$_pO_2$** (exercise)	**Qualified**[18]	**Comments**
DX 5	February 16, 1999 Cohen/Marder	36.1	78.3	No[19]	Normal.
DX 5 and 7	February 16, 1999 Cohen	34.0 35.2	81.6 72.2	No[20] No[21]	

CT Scan

On August 4, 1999, Dr. L. Malik conducted a CT scan of Mr. Shores' abdomen area and commented there were "no abnormal findings at lung bases" (CX 2).

Medical Evaluations[22]

Dr. Mark A. Shima

After several trips to the emergency room the night before due to burning chest pain and shortness of breath, Mr. Shores returned to the hospital in the early morning of June 26, 1998 (CX 2). Dr. Shima, board certified in cardiovascular disease and internal medicine,[23] examined Mr. Shores. He noted Mr. Shores' medical history included COPD, black lung, and hypertension. Mr. Shores had been a cigarette smoker for 20 to 30 years. Upon examination, all lung fields were clear. Laboratory tests presented evidence of a myocardial infarction. Consequently, Dr. Shima diagnosed acute inferior myocardial

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[18] To qualify for Federal Black Lung disability benefits, at a coal miner's given $_pCO_2$ level, the value of the coal miner's $_pO_2$ must be equal to or less than corresponding $_pO_2$ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. §718.

[19]For the $_pCO_2$ value of 36, the qualifying $_pO_2$ is 64.

[20]For the $_pCO_2$ value of 34, the qualifying $_pO_2$ is 66.

[21]For the $_pCO_2$ value of 35, the qualifying $_pO_2$ is 65.

[22]During the relevant time frame, Mr. Shores also received at least three treatments for physical ailments unrelated to his pulmonary, respiratory or cardiovascular systems on September 5, 1998, January 13, 1999, and April 23, 1999.

[23]As I informed the parties at the hearing (TR, page 6), I take judicial notice of Dr. Shima's board certification and have attached the certification documentation.

infarction with evidence of a prior infarction. Dr. Shima also included COPD with black lung disease in his summary.

Dr. William Degelman

On July 29, 1998, Dr. Degelman examined Mr. Shores in the Graham Hospital emergency room due to chest pain (CX 2). Mr. Shores' medical history included a myocardial infarction episode a month earlier. He also had a history of emphysema, COPD and black lung. Upon physical examination, the lungs were clear. Mr. Shores denied any shortness of breath. After receiving several negative lab tests, Dr. Degelman discharged Mr. Shores with a scheduled follow-up with a cardiologist.

Dr. C. Sanchez

On March 27, 1999, Mr. Shores arrived at the emergency room complaining about shortness of breath since the morning (CX 2). Dr. Sanchez recorded Mr. Shores' medical and social history, which included COPD, black lung and 35 years of coal mine employment. Mr. Shores was also a nonsmoker. Upon physical examination, Dr. Sanchez heard wheezes in the chest area. A chest x-ray indicated emphysema. Dr. Sanchez diagnosed "COPD exacerbation," treated Mr. Shores with a nebulizer, and then sent him home to rest.

Dr. Malik H. Dababneh

Dr. Dababneh served as Mr. Shores' treating physician. In November 1998, the physician noted "COPD/black lung" when examining Mr. Shores for coughing, wheezing, and a tight chest (CX 2). From January through April 1999, Dr. Dababneh again noted COPD when examining Mr. Shores for unrelated problems. Dr. Dababneh has also recorded a history of coronary artery disease. Finally, on August 3, 1999, Dr. Dababneh observed that Mr. Shores had a history of COPD, prostrate cancer and a triple aneurysm. An examination of the lungs revealed reduced breath sounds and good air exchange.

Dr. David Marder

On February 16, 1999, Dr. Marder, Board certified in internal medicine and occupational medicine,[24] examined Mr. Shores (DX 6). Dr. Marder noted Mr. Shores' history of coal mine employment, high blood pressure for ten years, and habit of smoking a half a pack of cigarettes per day for fourteen years before quitting 28 years ago. At the exam, Mr. Shores primarily complained of progressively worse dyspnea upon minimal exertion. Upon examination, Mr. Shores' lungs had bilateral diffuse wheezes. The pulmonary function test revealed moderate to severe impairment. The blood gas study did not reach the total disability threshold. The chest x-ray indicated the presence of COPD. Based on these tests, Dr. Marder diagnosed severe COPD and pneumoconiosis. These diseases were caused primarily by 31 years of exposure to coal mine dust and secondarily by cigarette smoke. Inhalation of coal

[24]I take judicial notice of Dr. Marder's board certification and have attached the certification documentation.

dust contributed greatly to this impairment since Mr. Shores smoked only one half a pack of cigarettes per day for only 14 years. Additionally, Mr. Shores' impairment is greater than the type caused by cigarette smoking alone.

Dr. David M. Skillrud

On January 2, 2000, Dr. Skillrud, board certified in internal medicine and pulmonary disease, examined Mr. Shores and subsequently rendered his medical opinion on March 24, 2000 based on the examination as well as his review of Mr. Shores' February 1999 records and a 1996 x-ray (EX 1). Dr. Skillrud noted that Mr. Shores quit smoking in 1970 after smoking a half a pack a day for 35 years. He retired from the coal mines in 1982 after 34 years. Mr. Shores had a history of chronic hypertension and myocardial infarction in 1996. During the examination, the retired coal miner complained of episodic hemoptysis, progressively worse dyspnea and wheezes, and a productive cough. Mr. Shores had used home oxygen therapy in the past, but at the time of the examination, he was not taking the therapy. Dr. Skillrud's examination of the lungs revealed diffuse bilateral wheezes with virtually every breath. The February 1999 x-ray reports from two B Readers found no evidence of pneumoconiosis, but did find emphysema. Additionally, the February 1999 pulmonary function tests suggested moderately severe obstruction. Dr. Skillrud concluded that Mr. Shores had chronic obstructive asthma. "In terms of causation, 'significant airways obstruction is indeed rare in coal miners in the absence of progressive massive fibrosis or cigarette smoking.' (Occup Environ Med 1994; 51: 234-238). In Mr. Shores' case, it clearly reflects chronic obstructive asthma aggravated by his prior tobacco use."

On May 27, 2000, Dr. Skillrud supplemented his March 2000 opinion (EX 3). Dr. Skillrud noted that the February 1999 pulmonary function tests revealed a moderately severe obstruction and a low diffusing capacity which, in conjunction with hyperinflation and/or emphysematous radiographic changes, is consistent with emphysema. The wheezes found on the January 2000 exam suggested a prominent broncho spastic (or asthmatic) component, while his productive cough suggested chronic bronchitis. Consequently, Mr. Shores' moderately severe COPD has elements of emphysema, asthma, and chronic bronchitis, none of which are related to his exposure to coal dust.

Dr. Jeff W. Selby

Dr. Selby, board certified in internal medicine and pulmonary disease and a B Reader, rendered a medical opinion on May 27, 2000, after reviewing the retired coal miner's entire medical record, including the results of Dr. Skillrud's examination (EX 2). According to the physician, Mr. Shores does not suffer from pneumoconiosis, as indicated by the negative chest x-rays. Reviewing test results within a year of Mr. Shores' retirement from coal mining, Dr. Selby observed that Mr. Shores did not suffer from any coal mine induced respiratory impairment and retained the respiratory and pulmonary capacity to perform his previous coal mine duties. As a result, the progressively worse obstruction Mr. Shores developed since his retirement from the mines is due to a baseline amount of emphysema from his cigarette smoking years and the development of bronchial asthma over the last 4-6 years, neither of which is related in any way to coal

mine dust exposure. Coal mine dust cannot cause bronchial asthma, it can only exacerbate already existent asthma. Mr. Shores did not have asthma when he worked in the mines. His recent onset of asthma, identified by the observed wheezing, can easily explain the development of the obstruction, dyspnea on exertion, and decline in oxygenation upon exercise. Additionally, the chest x-rays do not show any evidence of coal mine dust exposure by x-ray. "Finally, there is no sound medical literature that shows coal mine dust exposure, no matter how great, contributes in a clinically significant way to the development of chronic obstructive pulmonary disease in the absence of other common causes of chronic obstructive pulmonary disease, for example, bronchial asthma, chronic bronchitis, or emphysema."

On July 16, 2000, Dr. Selby provided further observations after considering Mr. Shores' medical records from Dr. Dababneh and the Graham Hospital (EX 4). Reaffirming his opinion that Mr. Shores does not have pneumoconiosis, Dr. Selby commented that although the term "black lung disease" is mentioned throughout these records, it is mentioned from a historical standpoint and nothing in the records indicates the existence of the disease. Instead, all of the chest x-rays were negative and there were no crackles heard indicative of pneumoconiosis. Mr. Shores does suffer from severe coronary artery disease that has caused at least three myocardial infarctions and three unstable angina admissions. This cardiac disability, along with his chronic smoke-induced emphysema and development of asthma, are the contributory factors to his shortness of breath. "Mr. Shores would have the respiratory and pulmonary capacity to perform any and all previous coal mine employment duties with the exception of his cardiac disease that is not at all related to coal mining and his emphysema and bronchial asthma which again are not related to coal mining employment."

Dr. Robert Cohen

On June 1, 2000, Dr. Cohen, board certified in pulmonary disease and internal medicine and a B Reader, rendered his medical opinion based on the February 1999 examination and testing as well as Mr. Shores' medical records, including Dr. Skillrud's examination and Dr. Selby's examination (CX 1). At the February 1999 examination, Mr. Shores' chief complaint was shortness of breath he experienced since leaving the mines in 1982. Mr. Shores had a history of hypertension and smoked a half a pack of cigarettes per day for 31 years until he quit 28 years ago.[25] Upon examination of the chest, the examining physician found bilateral diffuse wheezes. The x-ray of the chest taken in February 1999 was negative for pneumoconiosis and showed emphysematous changes. The pulmonary function tests revealed a normal FVC with mildly reduced FEV1 and severely reduced FEV1/FVC ratio. Lung volumes were normal and the diffusion capacity was reduced, indicating an altered gas-exchanging surface. The arterial blood gas studies revealed a severe obstructive defect with normal lung volumes. The sub-maximal exercise study showed a reduced work capacity and abnormal gas exchange.

[25]Dr. Cohen observed, upon reviewing Dr. Marder's report, that Dr. Marder incorrectly stated the duration of Mr. Shores cigarette smoking habit as 14 years.

Dr. Cohen opined that Mr. Shores suffered from pneumoconiosis. According to the physician, Mr. Shores has a chronic obstructive lung disease substantially related to his over 20 years of coal mine employment. His 16 pack year[26] history also probably contributed to his disease. His obstruction renders him unable to perform the tasks required by his last coal mining job as a welder. Mr. Shores' obstruction is indicated in several ways: dyspnea and chronic productive cough; the diffuse wheezing, increased chest diameter, increased resonance, and rare crackles and rhonchi seen in past physical exams; pulmonary function tests showing moderate COPD with moderate to severe diffusion impairment; resting and exercise arterial blood gas studies showing low $_pO_2$ with exercise and significant gas exchange abnormality; DLCO testing consistently showing moderate to severe impairment; and consistent emphysematous changes in the x-rays.

Regarding the diagnoses of asthma by Drs. Skillrud, Sidler, and Selby, the reversibility of the airways obstruction, which is one of the most important features of asthma, was not seen with Mr. Shores. Additionally, Mr. Shores had significant diffusion impairment, which is not a feature of bronchial asthma. Diffusion impairment occurs in emphysema and damages the air sacs and blood vessels of the lung. Asthma, on the other hand, only affects the airways and does not have low diffusion, but rather, may often have increased diffusion. Although Mr. Shores did have wheezing, this symptom is common in all forms of obstructive lung disease, including emphysema, chronic bronchitis, and asthma. Moreover, wheezing is a common symptom of a coal dust induced lung disease. Finally, Dr. Selby's diagnosis of newly onset asthma was mistaken because it cannot be said that Mr. Shores' lung function was indeed normal in 1981 when a diffusion test was not performed at that time and the spirometry did not rule out significant pulmonary abnormality.

Mr. Shores had two exposures which could have contributed to the development of his obstruction - tobacco smoke and coal dust exposure. As significant medical research has concluded, obstructive airways disease can result from coal mine dust exposure with or without the presence of pneumoconiosis. When coal dust causes or contributes to an obstruction, the patient experiences a significant impairment of the FEV1 associated with increased respiratory symptoms. Indeed, Mr. Shores' obstruction does result in a significant impairment in his FEV1 correlated with an increase in his respiratory ailments. Mr. Shores' degree of impairment clearly disables Mr. Shores from returning to his last job where he performed heavy manual labor.

Discussion

Clearly, the medical experts who evaluated Mr. Shores' pulmonary condition have differing opinions on whether pneumoconiosis is present in his lungs. Due to this conflict of opinion, I must initially assign relative probative weight to their diverse medical assessments. In evaluating medical opinions, an administrative law judge must first determine whether opinions are based on objective documentation and then consider whether the conclusions are reasonable in light of that documentation. A well-documented

[26]A pack year is equal to the consumption of one pack of cigarettes per day for one year.

opinion is based on clinical findings, physical examinations, symptoms, and a patient's work history. *See Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19 (1987) and *Hoffman v. B & G Construction Company*, 8 B.L.R. 1-65 (1985). For a medical opinion to be "reasoned," the underlying documentation and data should be sufficient to support the doctor's conclusion. *See Fields, supra.* In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probable weight to the most recent report. *See Clark v. Karst-Robbins Coal Company*, 12 B.L.R. 1-149(1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. *See Thorn v. Itmann Coal Company*, 3 F.3d 713 (4th Cir. 1993). Finally, a medical opinion may be given little weight if it is vague or equivocal. *See Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) and *Justice v. Island Creek Coal Company*, 11 B.L.R. 1-91 (1988).

Dr Dengelman, Dr. Shima, and Dr. Sanchez presented documented evaluations which included in Mr. Shores' medical history a diagnosis of black lung disease. However, while their examinations provided important medical background, their references to black lung disease carry little probative weight because they were merely documenting medical history without either agreeing with the diagnosis or explaining the basis for their opinion that Mr. Shores had pneumoconiosis. In other words, their historical notations about black lung are not well reasoned.

Likewise, while Dr. Dababneh, as Mr. Shores' treating physician, had significant contact with Mr. Shores, he did not explain the basis for his references to black lung disease. Also, because Dr. Dababneh did not specifically indicate the etiology of Mr. Shores' obstructive disease, his diagnosis of COPD has little probative value. In other words, although his treatment notes are well documented, his diagnosis of black lung disease has diminished probative value in the absence of any explanation of the medical basis of his conclusion.

Based on his pulmonary examination of Mr. Shores, Dr. Marder rendered a documented and reasoned medical opinion that Mr. Shores had pneumoconiosis and COPD due to coal dust exposure. However, as set out below, I give his opinion less probative weight due to inaccurate documentation and insufficient reasoning. First, Dr. Marder concluded Mr. Shores' severe COPD and pneumoconiosis were due primarily to coal mine dust because Mr. Shores only smoked a half a pack of cigarettes per day for 14 years. Based on that cigarette smoking history, Dr. Marder believed Mr. Shores impairment was greater than it would have been if 14 years of cigarette smoking at half a pack a day had been the only potential cause of the pulmonary condition. In other words, the 14 year duration of Mr. Shores' cigarette smoking habit is a pivotal factor for Dr. Marder in reaching his conclusion that exposure to coal dust is responsible, in part, for the COPD. However, Dr. Marder's cigarette history is incorrect by at least one-half. Mr. Shores smoked cigarettes for over 30 years at half a pack a day. Consequently, Dr. Marder's opinion is based on incorrect information. As a result, his diagnosis of pneumoconiosis in the form of coal dust related COPD is not well documented and has diminished probative value.

Dr. Marder's diagnosis of pneumoconiosis also has reduced probative value because he did not explain either the basis or documentation for his conclusion that Mr. Shores' impairment is greater than an impairment caused by his cigarette smoking. Notably, Dr. Marder did not indicate how he knew Mr.

Shores' impairment exceeded the expected impairment level that corresponds with a 14 year, half a pack per day, cigarette smoking history.

The remaining three physicians presented reasoned and well documented opinions, based on pulmonary examination reports and Mr. Shores' medical record. Dr. Skillrud and Dr. Selby opined Mr. Shores did not have a coal dust induced pulmonary impairment. On the other hand, Dr. Cohen diagnosed pneumoconiosis. Though Dr. Skillrud and Dr. Selby outnumber Dr. Cohen, I find , for several reasons, that Dr. Cohen's assessment is the most probative opinion in the record on the issue of pneumoconiosis.

In relative terms, Dr. Skillrud's and Dr. Selby's opinions are not as well reasoned as Dr. Cohen's assessment. Dr. Skillrud explains Mr. Shores' obstructive impairment in terms of emphysema, asthma, and chronic bronchitis. He reaches this conclusion because Mr. Shores wheezes and an obstruction caused by coal mine dust is "rare" in the absence of progressive massive fibrosis or a history of cigarette smoking. And, while Mr. Shores certainly has a history of cigarette smoking, the absence of progressive massive fibrosis demonstrated by chest x-rays apparently excludes the possibility of an obstruction due to coal dust. In other words, Dr. Skillrud requires the presence of fibrosis in chest x-rays before he will realistically consider the possibility of a coal dust-related obstruction impairment. In the absence of such radiographic evidence, Mr. Shores' breathing problems must be due to asthma.

Based on his observations, I believe Dr. Skillrud rendered his diagnosis on the basis of "classic" or medical pneumoconiosis. Under the regulations, any pulmonary impairment, both restrictive and obstructive, caused, or substantially aggravated, by exposure to coal dust may be considered pneumoconiosis. In light of the regulatory definition of pneumoconiosis, Dr. Skillrud's apparent requirement for radiographic evidence of massive fibrosis for a diagnosis of a coal dust related obstructive impairment is too narrow a focus. Certainly, the regulations establish the possibility that an obstructive impairment may be related to coal dust exposure, even in the absence of chest x-rays showing massive fibrosis. Dr. Skillrud did not consider that scenario. Instead, he reached his diagnosis of asthma and chronic bronchitis through the process of elimination without referencing any objective medical evidence that Mr. Shores' obstructive impairment, in the form of asthma, has a reversibility factor. Notably, while Dr. Skillrud did not accomplish a post-bronchodilator pulmonary function test, earlier pulmonary function tests in 1996 (see DX 18) showed little reversibility. Dr. Skillrud also apparently did not consider the possibility that coal dust exposure may have aggravated Mr. Shores' emphysema. Finally, Dr. Skillrud did not integrate as well as Dr. Cohen all the objective medical tests, including the arterial blood gas studies, which, according to Dr. Cohen, show some blood gas exchange abnormalities.

In a similar manner, Dr. Selby's opinion is not as well reasoned as Dr. Cohen's analysis because he also took a restrictive approach in analyzing Mr. Shores' pulmonary impairment in terms of medical pneumoconiosis. Significantly, Dr. Selby referenced the absence of medical literature to support the proposition that coal dust exposure may cause COPD. Dr. Selby also stressed the absence of chest x-ray evidence of exposure to coal dust in Mr. Shores' case. Such a medical viewpoint is narrower than the

broader regulatory definition of pneumoconiosis. By failing to address legal pneumoconiosis, Dr. Selby did not consider the relationship of coal dust exposure to Mr. Shores' emphysema. In addition, according to Dr. Selby, since Mr. Shores did not have a significant obstruction when he retired from coal mining, his present significant obstruction must be due to tobacco-related emphysema and the recent onset of bronchial asthma. Dr. Selby's reliance on Mr. Shores' pulmonary condition at the time of his retirement from coal mining to eliminate consideration of a coal-dust related obstructive impairment runs contrary to the legal notion that pneumoconiosis is a progressive disease. Within that analytical framework, Dr. Selby's choice of cigarette smoke rather that coal dust as the etiology of Mr. Shores' obstructive impairment seems less reasonable when considering that Mr. Shores stopped smoking in 1971, over a decade before he retired from coal mining. In other words, Mr. Shores' most recent exposure to a potential cause of a pulmonary impairment occurred while he was working as a coal miner. Finally, Dr. Selby, other than noting wheezes, did not indicate the objective medical basis for his diagnosis of asthma. And, Dr. Selby did not address the absence of a reversibility component in the 1996 pulmonary function tests.

In comparative terms, Dr. Cohen provided the best reasoned and documented medical opinion on the issue of pneumoconiosis. Unlike Dr. Skillrud and Dr. Selby, Dr. Cohen did analyze Mr. Shores' breathing impairment within the entire universe of regulatory pneumoconiosis. According to Dr. Cohen, Mr. Shores' exposure to both coal dust and cigarette smoke caused his obstructive impairment. He was able to include coal dust as a contributing factor in Mr. Shores' impairment because Mr. Shores suffered a decrease in the pulmonary function test FEV1 value with simultaneous increase in his respiratory symptoms. In addition, Dr. Cohen integrated all the objective medical evidence, including the chest x-rays and the arterial blood gas studies showing a blood gas exchange problem to reach his conclusion that coal dust exposure did contribute to Mr. Shores' obstruction. Dr. Cohen also presented the best documented medical opinion because he considered the analyses by Dr. Skillrud and Dr. Selby. After reviewing those contrary opinions, Dr. Cohen specifically, and reasonably, refuted their joint diagnosis of asthma. Referencing both the significant absence of any characteristic reversibility component and the presence of significant diffusion, Dr. Cohen did not believe Mr. Shores had asthma.

In summary, the preponderance of the most probative medical opinion, in the form of Dr. Cohen's conclusion that Mr. Shores has an obstructive breathing problem associated in part to his coal dust exposure, establishes the presence of pneumoconiosis. Since the evidence presented by Mr. Shores now establishes the first element of entitlement, he has demonstrated a material change in condition. Consequently, the entire record must be evaluated to determine whether Mr. Shores is entitled to benefits under the Act.

Issue # 2 - Entitlement to Benefits

Because Mr. Shores established a material change in his condition since November 1996, I must now review all of the medical evidence developed since his first claim in 1981 to determine if he can establish the four elements of entitlement for black lung benefits under the Act.

Pneumoconiosis

Because Mr. Shores' records since 1981 do not contain a biopsy report, he must rely on chest-ray evidence and medical opinion developed since his first claim to establish the existence of pneumoconiosis.

Chest X-Rays

Below are the relevant chest x-ray interpretations in the official record developed from Mr. Shores' first claim through November 1996.

Date of X-Ray	Exhibit	Physician	Interpretation
June 22, 1981	DX 16	Pittman, BCR, B	Negative for pneumoconiosis.
Same	DX 16	Reyes, BCR	Negative for pneumoconiosis, slight emphysema.
December 6, 1995	CX 2	Malik	Negative for pneumoconiosis. Mild to moderate emphysema, no acute cardiopulmonary disease. Increase in AP diameter of chest and flattening of diaphragms.
August 21, 1996	DX 19	Gaziano, B	Negative for pneumoconiosis.

Again, considering the entire history of radiographic evidence, Mr. Shores is not able to prove the presence of pneumoconiosis through chest x-rays.

Medical Opinion

Dr. Glen Sidler

On June 25, 1981, Dr. Sidler examined Mr. Shores (DX 16). At the time of the examination, Mr. Shores had a cumulative smoking history of ½ pack of cigarettes per day for twenty years. Mr. Shores complained of dyspnea upon exertion for six to seven years, chest pain for about eight years, and nocturnal dyspnea. Upon examination of Mr. Shores' chest, Dr. Sidler heard diffuse wheezes. The pulmonary function test was normal; the chest x-ray showed slight emphysema, and the blood gas study was abnormal in part. Dr. Sidler, without explanation, diagnosed Mr. Shores with chronic bronchitis and asthma. He checked "no" when asked if these were related to coal dust exposure.

Dr. Won Kim

On August 21, 1996, Mr. Shores was examined by Dr. Kim (DX 18). Dr. Kim noted a history of occasional colds and wheezing, two heart attacks, and high blood pressure. Mr. Shores was hospitalized in May 1996 for bronchitis and in the 1980's for heart attacks. He started smoking cigarettes

at age 22 and quit at age 48, after smoking a half a pack per day, although he never really inhaled. Mr. Shores complained of occasional sputum, daily wheezing, dyspnea, frequent coughing, occasional chest pain, and occasional paroxysmal nocturnal dyspnea. Upon examination, his lung diameter and resonance were increased, and the physician heard rare crackles in the bases and a low wheeze. An x-ray was negative for pneumoconiosis. The pulmonary function test demonstrated an obstructive impairment that was not reversible with a bronchodilator. Dr. Kim diagnosed the retired coal miner with COPD due to his abnormal physical findings and pulmonary functions. The COPD was probably due to coal mining and/or smoking. Finally, Mr. Shores had a moderate to marked physical impairment.

Dr. Malik Dababneh

On December 6, 1995, Mr. Shores was treated by Dr. Malik Dababneh at Graham Hospital for a cough, sputum, shortness of breath, and upper left chest pain (CX 2). Dr. Dababneh noted a history of COPD, hypertension, coronary artery disease, and two myocardial infarctions two years ago. He also noted that Mr. Shores quit smoking years ago but still chews one can of tobacco a week. Upon examination, Mr. Shores' lungs had increased breath sounds and some faint inspiratory and expiratory wheezes in the left upper lobe. Dr. Dababneh diagnosed Mr. Shores with acute exacerbation of COPD, acute bronchitis, hypertension, and arteriosclerotic heart disease. From January through October 1996, Dr. Dababneh found wheezes in Mr. Shores' lungs and noted discussing black lung disease and COPD with him.

Discussion

Upon consideration of these medical opinions, in conjunction with the previous assessments, I still find Dr. Cohen's diagnosis of pneumoconiosis the best reasoned and documented. Neither Dr. Sidler or Dr. Kim, in their terse medical reports explained the basis for their conclusions about the etiology of Mr. Shores' obstruction. Likewise, Dr. Dababneh's additional observations are not particularly probative because he did not discuss the causation of Mr. Shores' COPD and his reference to black lung disease has no accompanying explanation.

Accordingly, Dr. Cohen's opinion that Mr. Shores has pneumoconiosis remains the most probative of all the medical opinions. I find, based upon Dr. Cohen's well reasoned and documented opinion, that Mr. Shores' COPD is due in part to coal mine dust exposure. As a result, Mr. Shores has proven the first element of entitlement, the existence of pneumoconiosis in his lungs.

Pneumoconiosis Arose out of Coal Mine Employment

To establish the second element of entitlement to benefits, Mr. Shores must establish that his pneumoconiosis arose, at least in part, out of coal mine employment. If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Because the parties have stipulated that

Mr. Shores worked at least twenty-six years and six months in the coal mines, Mr. Shores is entitled to the presumption.

In rebuttal, the record does contain medical opinion that Mr. Shores' impairment is not related to his work as a coal miner. However, I find, once again based on Dr. Cohen's most probative medical opinion, that Mr. Shores obstructive impairment arose, at least in part, from his coal mine employment. Consequently, Mr. Shores has successfully established the second requisite element of entitlement.

Total Disability

The third necessary element for entitlement of benefits is total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §718.204 (b). If that presumption does not apply, then according to the provisions of 20 C.F.R. §718.204, in the absence of contrary evidence, total disability may be established by four methods: (1) pulmonary function tests; (2) arterial blood-gas tests; (3) a showing of cor pulmonale with right sided congestive heart failure; or (4) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area.

It is important to note in evaluating evidence regarding total disability, the total disability must be respiratory or pulmonary in nature. The Director of the Office of Worker's Compensation Programs has taken the position that to establish totally disability due to pneumoconiosis, a miner must *first* prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions. This approach has been challenged and upheld by at least one United States Courts of Appeals.[27]

Mr. Shores has not presented evidence of complicated pneumoconiosis or cor pulmonale with right sided congestive heart failure. Accordingly, Mr. Shores must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

[27]See *Jewell Smokeless Coal Corporation v. Street*, 42 F.3d 241 (4th Circuit 1994).

Pulmonary Function Tests (prior to November 1996)

Exhibit	**Date/ Doctor**	**Age/ height**	**FEV_1** pre[28] post[29]	**FVC** pre post	**MVV** pre post	**$\%FEV_1$/ FVC** pre post	**Qualified**[30] pre post	**Comments**
DX 16	June 22, 1981 Sidler	62 73"	3.07	4.17	137	74%	No[31]	Normal.
DX 18	August 26, 1996 Dabahbana	77 70"	1.52 1.52	2.64 2.86	48	58% 53%	Yes[32] Yes	Good effort. According to Dr. Sarah Long, vents are not acceptable, in part due to less than optimal cooperation, effort and understanding (DX 18).
DX 18	October 15, 1996 Dabahbana	77 70"	1.88 1.92	3.37 3.58	56	56% 54%	Yes No	Audible wheezing, good effort. According to Dr. Long, vents are acceptable (DX 18).

Under the provisions of 20 C.F.R. §718.204 (c) (1), if the preponderance of the pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary test evidence shall establish a miner's total disability. To apply this regulatory section requires a five step process. First, an administrative law judge must determine whether the tests conform to the pulmonary function test procedural requirements in 20 C.F.R. §718.103. Second, the results are

[28]Test result before administration of a bronchodilator.

[29]Test result following administration of a bronchodilator.

[30]To qualify for total disability, for a miner's age and height, the FEV_1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. §718, **and either** the FVC has to be equal or less than the value in Table B3, **or** the MVV has to be equal or less than the value in Table B5, **or** the ratio FEV_1/FVC has to be equal or less than 55%.

[31]The qualifying FEV_1 number is 2.25 for age 62 and 72.8". The associated qualifying FVC and MVV values are 2.86 and 90.

[32] The qualifying FEV_1 number is 1.88 for age 71 and 70.1". The associated qualifying FVC and MVV values are2.43 and 75.

compared to the qualifying values for the various tests listed in Appendix B to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these guidelines in mind, I find the six pulmonary functions tests in this record ranging from 1981 to 1999 do not establish total pulmonary disability. First, I note that all the tests are conforming,[33] and the two tests from August 26, 1996 and the first October 15, 1996 test did qualify under the regulations. However, Dr. Long provided a sufficient reason for questioning the validity of the two August 26, 1996 tests. As a result, I do not find that testing probative. Of the four remaining pulmonary functions tests administered on June 2, 1981 (one test), October 15, 1996 (two tests), and February 16, 1999 (one test), only one evaluation exceed the total disability threshold. That one test showing total disability is outweighed by the remaining three non-qualifying pulmonary function tests, including the most recent evaluation. The preponderance of the conforming, valid pulmonary function tests do not establish total disability.

[33]Even though the August 26, 1996 test is missing a tracing, the two tracings that are included in the record are sufficient to assess the validity of the test results. *See Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Arterial Blood Gas Studies (prior to November 1996)

Exhibit	**Date/ Doctor**	**$_pCO_2$** (rest) **$_pCO_2$** (exercise)	**$_pO_2$** (rest) **$_pO_2$** (exercise)	**Qualified**[34]	**Comments**
DX 16	June 22, 1981 Sidler	34 33	83 72	No[35] No[36]	At rest, there is very minimal acute respiratory alkalosis, but pO_2 is normal. With exercise, there is abnormal response and a drop in arterial pO_2.
CX 2	December 6, 1995 Dababadeh	37	73	No[37]	
DX 19	August 21, 1996 Kim	35	86	No[38]	

None of the arterial blood gas studies from 1981 through 1999 qualify to establish total disability.

Medical Opinion

When total disability cannot be establish based on the presence of complicated pneumoconiosis, cor pulmonale, qualifying pulmonary function tests, or qualifying arterial blood gas studies, a claimant may still establish total disability through reasoned medical opinion. According to 20 C.F.R. § 718.204 (c) (4), total disability may be found:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual or comparable coal mine employment.

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[34] To qualify for Federal Black Lung disability benefits, at a coal miner's given $_pCO_2$ level, the value of the coal miner's $_pO_2$ must be equal to or less than corresponding $_pO_2$ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. §718.

[35]For the $_pCO_2$ value of 34, the qualifying $_pO_2$ is 66.

[36]For the $_pCO_2$ value of 33, the qualifying $_pO_2$ is 67.

[37]For the $_pCO_2$ value of 37, the qualifying $_pO_2$ is 63.

[38]For the $_pCO_2$ value of 35, the qualifying $_pO_2$ is 65.

To evaluate total disability under this provision, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Exertional Requirements

Based on the above principles, the first step in my analysis is to determine the exertional requirements of Mr. Shores' last coal mine job as a main line motorman. Based on his hearing testimony, I find Mr. Shores engaged in heavy manual labor. In his last job, Mr. Shores welded at the tipple, on the drag line, at the loading shovel, and in the garage (TR, page 39). He regularly replaced the bottoms of the conveyer belts, repaired the crusher, and welded eight foot long drill stems. In the course of his welding duties, he had to lift and carry 80 pound drill stems at least 32 feet, remove 70-80 pound sections of old chutes, lift and move 100 pound truck axles to repair them, regularly climb the 300 foot boom of the drag line, and lift and move 75-80 pound sections of cable for the loading machines. With the assistance of others, Mr. Shores also lifted 300 pound sheets of steel used to replace the bottoms of coal chutes, and 300 pound I-beams (TR, pages 41-53).

Medical Evaluations

Having established the physical requirements of Mr. Shores' coal mine employment, I next review the medical opinion in the record to determine if the preponderance of the medical opinion supports a finding of total respiratory disability.

In his most probative medical opinion, Dr. Cohen determined Mr. Shores was totally disabled from a pulmonary perspective. Mr. Shores' dust-related COPD rendered him unable to perform the tasks required by his last coal mine employment as a welder.

None of the other physicians rendered a sufficiently probative opinion concerning Mr. Shores' disability. Based on his tests in 1981, Dr. Sidler may have believed Mr. Shores was not disabled, but he didn't make a definitive finding. In addition, due to the age of Dr. Sidler's report, it has little probative value on whether Mr. Shores is now disabled.

Dr. Dababneh, Dr. Degelman, Dr. Shima, and Dr. Sanchez did not comment on the extent of Mr. Shores' ability to work. In 1996, Dr. Kim diagnosed a moderate to marked physical impairment due to Mr. Shores' respiratory condition. However, absent a finding that the disability was total, his medical assessment falls short of proving the third element of entitlement.

Dr. Marder also did not make a definitive statement concerning total pulmonary disability. However, he concluded, based on pulmonary function tests, that Mr. Shores had a moderate to severe

pulmonary impairment.[39] His diagnosis, coupled with my finding that Mr. Shores engaged in heavy manual labor as a coal miner, supports a finding of total disability. In a similar fashion, Dr. Skillrud's finding that Mr. Shores suffered a moderately severe pulmonary obstruction helps support a determination of total pulmonary disability.

Finally, Dr. Selby opined that "Mr. Shores would have the respiratory and pulmonary capacity to perform any and all previous coal mine employment duties with the exception of his cardiac disease that is not at all related to coal mining and his emphysema and bronchial asthma which again are not related to coal mine employment." At the same time, Dr. Selby did not indicate that Mr. Shores' pulmonary condition, standing alone, without his cardiac problems, would sufficiently disable him from coal mine employment. As a result, Dr. Selby's assessment does not support a finding of total respiratory impairment.

After reviewing all the medical opinion, and finding little, probative, contrary evidence, I conclude Dr. Cohen's most probative medical opinion, as supported by Dr. Marder's and Dr. Selby's assessments on the severity of Mr. Shores' pulmonary condition, establishes that Mr. Shores is totally disabled due to a pulmonary impairment.

Total Disability Due to Pneumoconiosis

Because Mr. Shores has established three of the four requisite elements for entitlement of benefits, the award of benefits rests on the determination of whether his respiratory disability is due to pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Absent regulatory presumptions in favor of the claimant,[40] the miner must under 20 C.F.R. §718.204, as interpreted by the BRB and Federal Courts of Appeal, prove by a preponderance of the evidence that his pneumoconiosis is at least a simple contributing cause to his total disability. *Hawkins v. Director, OWCP*, 907 F.2d 697,707 (7th Cir. 1990).

Since there is no evidence of complicated pneumoconiosis and Mr. Shores filed his present claim after 1982, he is not able to rely on any of the regulatory presumptions. Instead, medical opinion in the record will determine whether Mr. Shores' total disability is due to pneumoconiosis.

In determining relative probative weight, I find, for the reasons previously noted, the opinions of Dr. Dababneh, Dr. Degelman, Dr. Shima, and Dr. Sanchez, and Dr. Sidler have little probative weight in

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[39]Since Dr. Marder relied on objective medical tests for this portion of his diagnosis, his conclusion on this issue is not diminished even though he also used an incorrect cigarette smoking history for other portions of his opinion.

[40]20 C.F.R. §718.305 (if complicated pneumoconiosis is present then there is an irrebuttable presumption miner is totally disabled due to pneumoconiosis); 20 C.F.R. §718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. §718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

determining whether Mr. Shores' total disability is due to pneumoconiosis. Because both Dr. Skillrud and Dr. Selby did not believe Mr. Shores had pneumoconiosis, their medical opinions also are not probative on this subject either. *See Hobbs v. Clinchfield Coal Co.*, 45 F. 3d 819 (4th Cir. 1995). And, Dr. Kim also did not discuss the cause of the moderate impairment.

Although Dr. Marder attributed Mr. Shores' pulmonary problems to coal dust exposure, I have previously dismissed his opinion on the subject of pneumoconiosis due to his reliance on an incorrect cigarette smoking history.

Once again, Dr. Cohen's diagnosis is the sole, remaining probative medical opinion. Dr. Cohen indicated coal dust exposure played a significant role in Mr. Shores' respiratory disability. Dr. Cohen found that of the two risk factors associated with Mr. Shores' lung obstruction, exposure to coal dust was a contributing cause. Based on the highly probative medical assessment of Dr. Cohen, I find the preponderance of the evidence establishes total disability due to pneumoconiosis.

CONCLUSION

The preponderance of the most probative medical evidence establishes that Mr. George W. Shores is totally disabled by pneumoconiosis which arose out of his coal mine employment. Having established all the requisite elements, Mr. Shores is entitled to benefits under the Act, augmented for one dependent, Mrs. Geraldine Shores.

Date of Entitlement

Under 20 C.F.R. §725.503 (b), in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable beginning the month of onset of total disability. When evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP,* 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson,* "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP,* 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Company v. Krecota,* 868 F.2d 600 (3rd Circuit 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but

believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his or her claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

Where there is no intervening medical opinions or evidence that raise the possibility that total disability did not exist between the claim filing date and the first medical evaluation that established total disability, then a different set of principles are applicable. In this situation, while the first medical examination after the claim was filed leads to a finding of total disability, the date of the examination showing total disability does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner had become totally disabled. See *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985).[41]

The pulmonary function test of October 15, 1996 gave some indication of Mr. Shores' impairment and Dr. Kim found a marked physical impairment. However, since Dr. Kim did not consider the physical requirements of Mr. Shores' coal mine work, I consider his report insufficient to establish onset of total respiratory impairment prior to the submission of the present claim. Consequently, I next consider the date of total disability onset in relation to the present claim.

Mr. Shores filed his present claim on November 21, 1998. Dr. Cohen based his findings of total disability, in part on the results of the February 16, 1999 pulmonary examination, which showed a moderately severe impairment. Since there is no intervening medical evidence to show Mr. Shores was not totally disabled during the period between the time he filed the claim in November 1998 and the February 1999 pulmonary examination, I find benefits are payable starting the month in which Mr. Shores filed his claim, November 1, 1998.

Attorney's Fee

Since I have not received an application from Mr. Shores' attorney for approval of a fee, I do not award attorney's fees at this time. Mr. Shores' attorney has thirty days from receipt of this decision to submit an application for attorney's fees in accordance with 20 C.F.R. §§752.365 and 725.366. With the application, counsel must attach a document showing service of the application upon all parties, including Mr. Shores. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

[41]In that case, the BRB stated the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset."

ORDER

The claim of GEORGE W. SHORES for benefits under the Act is **GRANTED**. The employer, MIDLAND COAL COMPANY, is ordered to pay the claimant all benefits to which Mr. Shores is entitled under the Act and Regulations. Benefits shall commence November 1, 1998, augmented for one dependent.

SO ORDERED:

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.